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California Department of Mental Health

Performance Outcomes Update

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Adult Performance Outcomes: Definition of "Link Date"

We are aware that there is some confusion regarding the definition of the "Link Date" which is found on each of the adult performance outcome survey instruments. The link date is what we are using to link sets of forms that were administered to a client at a given assessment. The specific date that is entered in the link date field is not nearly so important as the fact that **the link date should be the same on each instrument for a given administration**. Think of the link date as a unique identifier (kind of like a Social Security Number) that uniquely identifies a specific set of instruments from other sets that exist for that same client.

Some counties are using the month and day of the client's intake date as their link date along with the current year (note, the link date "year" must be the current year the instruments were administered). Other counties are using the date that the coordinated care plan was developed. Still others are using the date that the instruments were scheduled to be administered. Each of these is an acceptable approach.

It is recommended that clerical staff, **before giving the forms to the clinician** for distribution to the client, enter the link date in that field. This date **must** be the same on all of the forms for a given administration time (i.e., intake, annual review, discharge).

Below is an example of four administrations of the instruments to a client beginning at their intake on June 1, 1999 and continuing over the course of three years with a discharge taking place in the third year. Note that the link date "day" is the same each year; however, the year for the link date is always the current year. Again, it is critical that the same link date be entered on each of the forms for a given administration.

Type of Administration	Link Date	Instruments Administered
Intake	June 1, 1999	GAF BASIS-32 Quality of Life
Annual Administration	June 1, 2000	GAF BASIS-32 Quality of Life MHSIP
Annual Administration	June 1, 2001	GAF BASIS-32 Quality of Life MHSIP
Discharge	November 3, 2002	GAF BASIS-32 Quality of Life MHSIP

Should you have any questions about the format of, or how to use the link date, please email Traci Fujita at tfujita@dmhhq.state.ca.us .

Would you like to contribute to the California Department of Mental Health's Performance Outcomes Update (POU) ? If you or your county are using performance outcome data to improve your programs, or if you have identified a novel way to analyze data to determine program effectiveness, and would like to share this with others, why not submit an article to the POU? It needs to be concise and kept under 800 words. Send your article to Roxane Gomez, CA Department of Mental Health, 1600 9th St., Rm. 130, Sacramento, CA, 95814, or rgomez@dmhhq.state.ca.us .

Inside This Edition

Upcoming Meetings

Older Adult Performance Outcomes
October 12, 2000, 10:00 - 2:00 PM
Department of Mental Health
1600 9th Street, Room 250 A
Sacramento, California

COLUMBUS DAY
MONDAY, OCTOBER 9, 2000
CA State Offices Closed

Children's Task Force
November 7, 2000, 10:00 - 3:00 PM
Sacramento Host Airport Hotel
American Room

"Visit our Website!"

RPOD staff are working hard to keep the Research and Performance Outcome Development Website up-do-date with the latest information including reports, graphs, statewide results, copies of the instruments that will be piloted as potential replacements for the current Children's Performance Outcome System, and other important information.

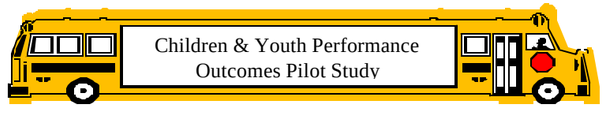
Our address http://www.dmh.cahwnet.gov/rpod

Research & Performance Outcome Development

Pilot Testing an Alternative for the Current Children's Performance Outcome System

Brenda Golladay
Children's Performance Outcomes

In late 1999 a survey statewide survey was conducted to get feedback from a wide variety of stakeholders regarding the Child & Youth Performance Outcome System. Specifically, clinicians, program managers, children's evaluators, mental health directors, MIS staff, parents, and representatives of the California Mental Health Planning Council were asked about their feelings and concerns regarding the current system and what kinds of things that they felt were critical to consider when the next generation of the Children's Performance Outcome System is designed (For details regarding the survey results, visit the Research and Performance Outcome Development website and look under the Children's Program). There was an overwhelming response that some of the instruments were too labor intensive, costly, and did not provide the kind of information that was either desired or useful for outcomes. In addition, stakeholders identified the criteria they felt were most important for the collection of outcome data. The top five criteria included: 1) The system must have included data collected from multiple informants, (Continued on Page 2)



2) The instruments must be psychometrically valid and reliable, 3) The instruments must be short and easy to administer, 4) The instruments must have little or no cost (public domain preferred), and 5) The data collected must be cost effective (value of the data per time and cost).

After meeting for a year and a half, a Task Force consisting of child psychiatrists, researchers, children's program evaluators, children's program managers, clinicians, family members, representatives of the CMHPC, as well as the California Departments of Mental Health, Social Services, and Education has selected instruments to pilot test that may address many of the shortcomings of the current system.

The Task Force identified the Ohio Scales, developed by Dr. Benjamin Ogles at Ohio State University as the best alternative to test because these scales are short, address functional impairments, as well as strengths, include a parent, child, and clinician scale, are offered to California at no cost, and finally they were designed specifically to measure outcomes in mental health systems such as those found in California. The Ohio Scales were also recommended by researchers at Vanderbilt University after a comprehensive evaluation of instruments that are currently available for large-scale mental health outcomes research.

In addition to the Ohio Scales, a Client Identification/Risk Factor Assessment form has been designed to collect specific information on client characteristics and risk factors. This information will facilitate a better understanding of the children and families served by California mental health service system as well as make the valid interpretation of outcome data possible. The following chart specifies the current instruments and introduces the corresponding alternative instruments that will be tested:

Current Instrument	Proposed Replacement Alternative Instrument
Child and Adolescent Functional Assessment Scale (CAFAS)	Ohio Scales – Clinician Version
Child Behavior Checklist (CBCL)	Ohio Scales – Parent Version
Youth Self Report (YSR)	Ohio Scales – Youth Version
Client Living Environment Profile (CLEP)	Client Living Environment and Stability Profile (CLESP)
N/A	Client Information/Risk Factor Assessment

The DMH Research and Performance Outcome Development Unit (RPOD) has mailed a solicitation letter to all California Mental Health Directors seeking volunteer counties who want to participate in a pilot test of the alternative instruments for the Children and Youth Performance Outcome System. Essentially, counties would administer the pilot instruments to a small sample of clients at time 1 and then again at six months. After completing the forms, county staff would fax the instruments to the DMH TELEform data collection system. Upon completion of the pilot study and with thorough collaboration of all of the stakeholders involved in the Children's Performance Outcome System, a decision regarding whether or not to replace the current system with the new instruments will be made. Any transition to a new system will be necessarily flexible in an effort to ease the transition and to assure that programs who have received grant funds based on using the current instruments as their evaluation component will not be disrupted.

For more information about the "Survey On Existing Children's Performance Outcome System", or to view the alternative instruments, please visit the DMH website at www.dmh.ca.gov. For more information about the pilot study, or if you are unable to access the DMH website, please contact Brenda Golladay at bgollada@dmhhq.state.ca.us or call her at (916) 654-3291. We at DMH look forward to collaborating with all involved stakeholders so that we may better serve the children and families of California for their mental health.

Property Crime Victimization of Dually Diagnosed Clients

Candace Cross-Drew
CA State Project Research Director

Last month we reported that dually diagnosed clients were far more likely to be victims of violent crime than either the general U.S. population or adults with severe and persistent mental illness who are included in the California Adult Performance Outcomes System. We also reported that adults with severe and persistent mental illness who are included in the Department of Mental Health's California Adult Performance Outcomes System were more likely to be victims of violent crime than was the general U.S. population. Unfortunately, this same disparity appears to be true for property crimes as well. Data for these findings come from an on-going study of integrated treatment programs for Dually Diagnosed clients that is being sponsored by the California Department of Mental Health and the California Department Alcohol and Drug Programs.

Property crimes, such as burglary or theft, are the most frequent types of crime in the United States. Using data from a question on the California Quality of Life (CA-QOL) instrument, we can compute a victimization rate for property crimes. A section of the CA-QOL dealing with Legal & Safety issues asks clients if they have been a victim of a property crime within the last 30 days. Out of 336 clients, 111 clients answered "yes," to this question. To convert this number into a rate per 1,000 people, we divide 111 by 336 and then multiply the product by 1000. We get a victimization rate of 330 property crime victims per 1,000 people per month.

By way of comparison, we can look at the National Crime Victimization Survey (NCVS) for 1998 (the last year for which data are available). These data are collected annually based on data derived from a continuous survey of a representative sample of housing units in the United States. Note that the questions concerning victimization are not the same in the NCVS data and the CA-QOL, they are worded differently. Moreover, the NCVS uses a different time frame for its questions. Nonetheless, the NCVS data do provide a reasonable basis for comparison. NCVS reports a property crime victimization rate of 217 persons per 1,000 population per year. If we calculate a monthly rate for the NCVS (217 ? 12), we get a rate of 18 property crime victims per 1,000. This suggests that dually diagnosed mentally ill adults are victims of property crimes 18 times more often than the general U.S. population!

For another comparison we can look at responses to the CA-QOL given by adults with severe and persistent mental illness (SPMI) in the Adult Performance Outcome System. These data suggest that SPMI adults are victims of property crime at the rate of 125 victims per 1,000 SPMI. This rate is almost seven times greater than the US general population rate of 18 per 1,000 general population.

Just as with violent crime victimization, these findings suggest that adults with severe and persistent mental illness, and especially those who are dually diagnosed, are far more likely to be victims of property crime. While the U.S. general population reports a property crime rate of 18 victims per 1,000 population, dually diagnosed adults report 330 property crime victims per 1,000 people and adults with severe and persistent mental illness report 125 property crime victims per 1,000 population. For further information, please contact: Candace Cross-Drew, (916) 653-4582, ccross@dmhhq.state.ca.us .